Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Quality & Risk Committee (Part 1)
(Sub Committee of the Board of Directors)
Quarter 3, Month 2

Held on 26th November 2019
2.30 – 4.30 pm
3rd floor offices, rooms 3 & 4

M I N U T E S

Present			
	Michael Blastland	**(MB)**	**Non-executive Director (Chair)**
	Carole Buckley	**(CB)**	**Assistant Director of Quality & Risk**
	Dr Roger Hall	**(RH)**	**Medical Director**
	Dr Nick Morrell	**(NM)**	**Non-executive Director**
	Stephen Posey (until 3.47 pm)	**(SP)**	**Chief Executive**
	Josie Rudman (until 4pm)	**(JR)**	**Chief Nurse**
	Dr Stephen Webb	**(SW)**	**Associate Medical Director and Clinical Lead for Clinical Governance**
In Attendance	**Ivan Graham**	**(IG)**	**Deputy Chief Nurse**
	Anna Jarvis	**(AJ)**	**Trust Secretary**
	Oonagh Monkhouse (until 3.20 pm)	**(JS)**	**Director of Workforce & Organisation Development**
	Kate Pollard	**(KP)**	**Quality Compliance Officer**
	Chris Seaman	**(CS)**	**Executive Assistant (Minute taker)**
	Cath Willcox (until 3 pm)	**(CW)**	**Information Governance Manager**
Apologies	**Dr Jag Ahluwalia**	**(JA)**	**Non-executive Director**
	Richard Hodder	**(RH)**	**Lead Governor**
	Andy Raynes	**(AR)**	**Director of Digital**
	John Syson	**(JS)**	**Deputy Director of Workforce**

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1	**APOLOGIES FOR ABSENCE**		
	The Chair opened the meeting and apologies were noted as above.		
2	**DECLARATIONS OF INTEREST**		
	There is a requirement that those attending Board Committees raise any specific declarations if these arise during discussions. The following standing Declarations of Interest were noted: • Michael Blastland as Board member of the Winton Centre for Risk		

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	and Evidence Communication; as advisor to the Behavioural Change by Design research project; as member of the oversight Panel for the Cholesterol Treatment Trialists' Collaboration and as a freelance journalist reporting on health issues. • Josie Rudman, Partner Organisation Governor at CUH; Executive Reviewer for CQC Well Led reviews and Vice Chair of the Cambridgeshire and Peterborough Joint Clinical Group • Nick Morell Acting CEO Morphogenics biotech company from 1 April 2018 and as a member of the Regent House of the University of Cambridge. • Stephen Posey in holding an Honorary contract with CUH to enable him to spend time with the clinical teams at CUH; as Chair of the NHS England (NHSE) Operational Delivery Network Board; as Executive Reviewer for CQC Well Led reviews and Chair of the East of England Clinical Cardiac Network Group. • Roger Hall as a Director and shareholder of Cluroe and Hall Ltd, a company providing specialist medical practice activities.		
3	**MINUTES OF THE PREVIOUS MEETING – 15 October 2019**		
19/129	The Committee noted one alteration to the minutes on page 3 to 6.1.1.1c: *The Chair requested benchmarking that provided a comparison over time against historic performance at the Trust and a comparison with other cardiac centres with a similar level of patient acuity.* **Approved**: Following the amendment noted above, the Quality & Risk Committee approved the Minutes of the meeting held on 15 October 2019 and authorised these for signature by the Chair as a true record.		
4	**MATTERS ARISING AND ACTION CHECKLIST PART 1 (191015)** The action checklist was reviewed and updated.		
5.1	**QUALITY**		
5.1.1	**QUALITY EXCEPTION REPORTS**		
5.1.1.1	**QRMG Exception report** The Assistant Director for Quality & Risk presented the Exception Report. Highlights in the Q2 Quality and Risk report were noted: • Incident reporting remained healthy with 950 patient incidents reported in quarter. • There had been an increase in Pressure Ulcer (PU) incidents due to the inclusion of all category 1 PUs and moisture lesions. • VTE risk assessment compliance remained a challenge however the compliance rate had improved. • The Patient Advisory Liaison Service (PALS) continued to receive a significantly increased number of enquiries since relocation to the new site. PALS reported a change in the feelings and emotions of complainants with an increase in levels of anxiety, agitation and anger, with people appearing more upset and frustrated. The perception was that issues were more magnified by the time they reached PALS than before. The possible reasons behind this were discussed by the Committee. These included: o The PALS office was far more visible/central. o We should be minded that patients and families had also		

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	undergone a significant period of change. o Expectations were higher in the new hospital and this had been amplified by the recent Outstanding CQC rating. The Associate Director of Quality & Risk reported that staff training sessions around managing concerns raised at the point of service were going to be introduced. Early personal intervention was considered to be important. IG said that this had been discussed recently at a Band 7 meeting, with senior staff asked to implement good practice by dealing with issues at the point of complaint rather than allowing these to be deferred to PALS. The Chief Executive Officer noted that PALS were obviously doing a superb job as despite the increase in PALS issues the numbers of formal complaints remained low. The Chair invited PALS to a future Committee meeting to present a Staff Story. • The bereavement service contract with CUH was not performing to the standard wished for, so preliminary conversations with the service lead at CUH were underway. The Associate Director for Quality and Risk declared that, as the Trust wanted to deliver the best service for its families, she was considering bringing the service back to be co-ordinated by PALS. She was currently seeking advice from the Contracts Team; one formal complaint about the service had already been received. She agreed to report back to this Committee when she had a further update. A potential CIP was noted, whereby CUH mortuary charges were by the day for deceased patients; she was minded that PALS would operate a more efficient bereavement service thus reducing the time the families' deceased loved ones were held in the mortuary. • Rigorous investigations into the M.abscessus outbreak in transplant patients had continued. Mitigations of the risk had been put in place immediately with the installation of Point of Use filters for vulnerable patients and the distribution of bottled water. The source of the infection had still yet to be identified and this process was likely to be lengthy given the time taken to grow the cultures. Legal advice had been taken and communications to patients and staff were being reviewed. • Two further serious incidents had occurred since the last meeting: o **SUI-WEB32857 -** Patient death following complications after Aortic Balloon Valvulopalsty (BAV) o **SUI-WEB32980 -** Patient fall – Fractured neck of femur Further details would be available at the next meeting. • An increase of PFI related incidents was noted with water quality issues as one of the top reasons. • Six non-clinical claims were ongoing.		
5.1.1.2	**QRMG minutes (191008)** These were noted by the Committee.		
5.1.1.3	**Response to ICNARC** (Intensive Care National Audit & Research Centre) This report highlighted the CCA response to the ICNARC notification as a potential outlier for returns to critical care within 48 hours. The Associate Medical Director advised that tolerance had gone back to within expected		

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	levels but that regular scrutiny of readmissions would continue through robust analysis of clinical methods. Benchmarking was against all critical units in the UK however further detailed analysis of data from the cardiac units was still to be done. It was noted that to become too risk averse in cardiothoracic practice, in order to keep the number of returns to CCA to a minimum, would possibly put other patients at risk. The number of returns did not correlate with the mortality rate.		
5.1.1.4	**Q2 Quality & Risk Report 19/20** The Committee accepted this report. The Chair asked a general question on the trends in patient safety as to whether there had been a rise in incidents around the time of the hospital move. The Deputy Chief Nurse considered that this might be reflective of the ramp up in activity after the move following the ramp down. It was agreed that the data needed to run for longer prior to this period to ascertain a clearer picture of whether this was a temporary blip or indicative of a more worrying picture. It was noted that the severity of incidents had not increased in line with the number. Further reassurance was requested by the Chair for the next meeting.	CB	Dec 19
5.1.1.5	**Q2 Directorate and Business Unit Reports 19/20** The Committee accepted this report.		
5.1.1.6	**SIERP Dashboard** This was noted by the Committee.		
5.1.1.7	**BAU risks not previously reported to Q&R (191107)** This report was noted by the Committee.		
5.1.1.8	**QISG Minutes (190924)** These were noted by the Committee. The Assistant Director reported that a new member of staff with a QI background had been appointed and the Committee would see a refreshment of the QI projects in the New Year. The focus would be on the culture of improvement as well as the methodologies. Some Masterclass training, to commence in January 2020, had been commissioned to develop staff to support QI and a faculty to deliver standard training at a base level and more in depth training for project leads.		
5.1.1	**Fundamentals of Care Board (FOCB) Exception Report** The Chief Nurse gave a verbal update from the meeting held on 13 November 2019. The FOCB had received the CQC report and progress on the 'should do' actions had been reported and discussed. Alison Smith, our CQC Liaison Officer would be visiting the Trust on 28 November 2019 to review these. The Chief Nurse advised that she would be expecting a visit from the CQC sometime in the New Year to review the End of Life care but that in the meantime this would be a focus for the next mock CQC inspected planned for February 2020.		
5.1.2	**Minutes of FOCB** The minutes of the meeting held on 13 November 2019 were not available at the time of the Committee meeting.		
5.2	**PATIENT EXPERIENCE**		

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5.2.1	**End of Life Care Strategy** Dr Sarah Grove, Consultant, Palliative Care, attended the meeting to present the refreshed End of Life Care Strategy. She introduced herself and informed the Committee that she undertook three sessions a week at RPH. Her colleagues in the Palliative Care team consisted of a registrar on four sessions, two Band 7 nurse specialists and a part time secretary. Succession planning had commenced with 2 Band 6 nurse posts. Face to face access to end of life care was available during the week. Although there was no weekend service at present, palliative care link nurses were in place and the Alert team was trained to assist with end of life prescribing. There was an out of hours on call consultant telephone service and there had been a discussion with CUH about shared services over weekends. This had resulted in some nervousness about the skill differences required to deal with Royal Papworth patients who were in the main, not oncology patients, and this had not been progressed further. The Chief Nurse commented that Dr Grove and her team had made excellent progress in supporting patients and families in the Critical Care environment. The Royal Papworth strategy was based on a national framework containing six ambitions for improvements in end of life care. Dr Grove's key message was that staff should be prepared to care for people who are dying and not see it as a failure of treatment. Her aim was for patients to experience the best possible care at the end of their life. The Palliative Care team worked closely with other services in similar areas, chaplaincy, and psychology, etc. Dr Grove explained the use of the ReSPECT document due to be rolled out at the beginning of February 2020. By promoting discussion early on the end of life pathway this would help patients to live with difficult symptoms as well as they could for as long as they had left. It was a tool to ask patients important questions about what was most important to them, what they feared the most and what they would wish to happen in the event of a sudden deterioration, thus promoting shared decision making. She advised that she was in the progress of investigating an end of life care plan on Lorenzo with the Digital team which would assist, for example, with the audit of hydration documentation.		
5.2.2	**Minutes of EoL Steering Group (190926)**		
	These were accepted by the Committee		
5.3	**PERFORMANCE**		
5.3.1	**Performance Reporting/Quality Dashboard**		
5.3.1.1	**PIPR summary M07** This was circulated to the Committee for information		
5.3.1.2	**PIPR Safe M07** Safe was amber in month 7. There was a monthly Spotlight on Safe Staffing. The SafeCare-Live roll out was completed as per plan and the implementation lead continued to liaise with Ward Sisters and teams to deliver training as required. Some areas were still under the 90% fill rate, though continued to report a healthy level of Care Hours Per Patients Day. A narrative on Sepsis was also part of the PIPR report.		
5.3.1.3	**PIPR Caring M07** Caring remained green in month 7. Friends and Family Test (FFT)		

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	remained green for Inpatients (96.1%) and Outpatients returned to green for (95%), following further work by the Outpatients Sister and team. This work continued, particularly as the activity review of outpatient clinic use remained in progress as part of the optimisation work (i.e. increasing numbers of patients through outpatients, impacted on the number of FFT surveys required). Electronic options were being considered for FFT to eliminate paper.		
5.3.1.4	**PIPR People, Management & Culture (PMC) M07** PMC remained red in month 7.		
5.3.2	**Monthly Ward Scorecard: M07** The Chief Nurse advised that what was reflected on PIPR played out on the scorecard and that the Rostering Manager was working hard on the roster templates to ensure that they were accurate. The Chair asked if staff on the wards were persuaded that things were improving. Both the Chief Nurse and Deputy Chief Nurse felt that some staff still felt quite embattled in specific areas. The Chair expressed concern about the state of mind and personal well-being of staff. Whilst there is a test of resilience in some areas with an increase in short term sickness, the Deputy Chief Nurse advised that this had not translated across to patient surveys or HR figures. It was generally agreed that there were mixed emotions within different groups of workforce and that the leadership team needed to remain visible and accessible to provide support when required. The Chief Nurse and Deputy Chief Nurse had held coffee mornings and undertaken shifts in some areas respectively, giving staff the opportunity to approach them. Responding in a timely fashion to the small things like timely supply of scrubs and adequate hydration in theatres had proved challenging due to PFI issues and it was these types of issues that seem to cause the most angst amongst staff.		
5.4	**Safety**		
5.4.1	**Serious Incident Executive Review Panel (SIERP) minutes (191008, 191015, 191022, 191029, 191105, 191112 and 191119** The SIERP minutes were noted by the Committee.		
5.4.2	**Antimicrobial Stewardship (AMS) Report - Q2 2019/20** The Committee accepted this report and noted the continued slight improvement in the reduction of antibiotic usage within the Trust. Other highlights were the success of the World Antibiotic Awareness Week – November 18th - 23rd 2019 and the ratification of the refreshed Antimicrobial Strategy.		
6	**RISK**		
6.1	**Board Assurance Framework: Committee Open Risks November 2019** The Trust Secretary presented the report to the meeting. There were no changes in risk rating for the Committee BAF risks. She reported increased response levels for the Staff Engagement Survey at 55.4% (compared to 54% in 2018), due to close on 29 November 2019.		
7	**GOVERNANCE**		
7.1	**SIRO Report Q2**		

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	Cath Willcox, Information Governance (IG) Manager, presented the highlights of the Quarter 2 report in the absence of the Director of Digital. • IG toolkit submission was underway with the final submission date in March 2020. • There were a similar number of IG incidents in comparison to the last quarter however there had been a gradual overall decline in incidents over time. There were a couple of unusual incidents noted including patient identifiable data lost by a courier company in the United States. Duty of Candour had been completed with all six patients involved. Other incidents included 17 electronic misfiles by administrative staff but a decrease in the number of handover sheets found lying around was noted. • A new Information Asset Register (IAR) co-ordinator has been recruited and staff could now expect a reminder to update assets; improved compliance was required as this was currently red on the IG dashboard. • There were no Freedom of Information breaches or Subject Access Requests. • The Cyber dashboard was all green. • There were four new Impact Assessments in the quarter. There was a discussion on the level of IG training compliance and whether the content of this was robust enough to ensure that staff understood their responsibilities, given the recent phishing exercise. There was further discussion on what more could done by way of communication to ensure staff awareness of cyber security was heightened. The Director of Digital would be asked to respond to this and discuss further with Executive Directors.	AR	
7.2	**QIA Assurance Report**		
	This was accepted by the Committee.		
7.3	**Phishing Simulation Analysis**		
	The recommendations of the paper were noted and discussed at 7.1 and a second simulated phishing exercise has already been commissioned.		
7.4	**Advice for E-Mail Delegation**		
	It had been recognised and approved at IGSG that an amendment to the Acceptable Use Policy, to include advice on e-mail delegation for both e-mail account owners and delegates, was required. Although there had been no incidents to date related to this, the Director of Digital had wanted to reach a wider audience; it will be highlighted at the Monday briefing.		
7.5	**Emergency Preparedness, Resilience & Response (EPRR) Assurance Process - Core Standards Compliance update** The Quality Compliance Officer updated the Committee that a Deep Dive meeting was carried out on 18 October 2019 by Sharon Fox, Associate Director of Corporate Affairs (CCG Secretary) NHS Cambridgeshire & Peterborough CCG and Andy Dunn, Head of EPRR, NHSE/I. This had focused on the following domains of the EPRR Core Standards Self-Assessment: • Governance • Duty to maintain plans		

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	• Co-operation • CBRN It was decided that more evidence was required and the Trust remained partially compliant. Following the Deep Dive meeting, sufficient assurance was supplied through submission of an action and work plan to address the findings to conclude that we would return to substantially compliant by March 2020. Another site visit was planned for the New Year to check progress. The Chair acknowledged that this was a large amount of work for something very unlikely to occur and the Deputy Chief Nurse thanked Kate Pollard for all her hard work on this.		
7.6	**EPPR – Evacuation Plan update** A table top exercise with a scenario for a major campus evacuation was planned. The Associate Director for Estates and Facilities had linked with campus partners and regional exercises had been attended.		
7.7	**Terms of Reference – Quality & Risk Committee** Following discussion of Committee Membership and scheduling, it was proposed by EDs that both the Chief Executive and the Director of Workforce & Organisation Development should become voting members of the Quality and Risk Committee. This was approved and would be presented for ratification at the next Board meeting.		
7.8	**Terms of Reference – Patient & Carer Experience Group** The Deputy Chief Nurse advised that these had been ratified by the Patient and Public Information Committee the previous day and were presented to the Quality and Risk Committee for information.		
7.9	**Terms of Reference – Clinical Professional Advisory Committee** The TOR were not available in time for the meeting.		
7.10	**Terms of Reference – Safeguarding Committee** The TOR were not available in time for the meeting.		
8	**ASSURANCE**		
8.1	**Internal Audits**		
	There were none.		
8.2	**External Audits/Assessments**		
8.2.1	**External Peer Review of the Adult Congenital Heart Disease (CHD) – Level 2 Service and associated action plan** The peer review report showed a rating of 'Serious Concern' in some areas however the Medical Director perceived that despite this, the review had gone well, and concluded that adherence to metrics, irrespective of the size of the service produced a misleading outcome as some markers were not applicable to RPH. There were commonalities between the CHD and Transplant services; staffing was shared across both services and in practice no patient was deprived of a dedicated nurse. The service provided was of high quality and fell under the governance structure of St Guy's and Thomas's in London. The Chair asked for a report to the Quality and Risk Committee explaining the Trust's response to the report and its mitigations.	RH/EM	

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9	**POLICIES AND PROCEDURES**		
9.1	**Cover Paper to the changes to the Antimicrobial Strategy** The contents of this paper were accepted by the Committee.		
9.2	**DN182 Antimicrobial Strategy** This was ratified by the Committee.		
10	**RESEARCH AND EDUCATION**		
10.1	**Research**		
10.1.1	**Minutes of Research & Development Directorate meeting (190913, 191011)** These were noted by the Committee. The Medical Director initiated a discussion on the five clinical consultant academics supported financially by the Trust and for whom most, had their clinical program in place at RPH. He considered that the Committee should request a regular written report and presentation from the clinical academics, commensurate with the size of investment The Trust was both interested, and a partner in their research. It was agreed that the Chair would draft a request for review by the Medical Director and Dr Morrell which would be copied to Patrick Maxwell, Regius Professor of Physic, for information.	MB/RH/ NM	
10.2	**Education**		
10.2.1	**Clinical Education Q1/2 Report** This was presented to the Committee by the Deputy Chief Nurse.		
10.2.2	**Education Steering Group (ESG) minutes** There were no minutes available; the Deputy Chief Nurse explained that the ESG was to meet later in the week with the dates for 2020 meetings to be realigned to fit with the reporting timetable of the Quality and Risk Committee. He reported that the Assistant Director for Education was working on the allocation of CPD monies. He advised that the ESG wished the Quality and Risk Committee to be aware of the challenges and risks ahead, with the loss of clinical education space due to the opening of increased acute cardiology beds. Clinical supervision space was required for clinical simulation as well as manual handling and hoist training. Creative ideas to use the current space differently to enable this training to continue would be required until the opening of the HLREI in 18 months' time.		
11	**OTHER REPORTING COMMITTEES**		
11.1	**Clinical Professional Advisory Committee (Minutes from 190917, 191024)** Both sets of minutes were noted by the Committee.		
11.2	**Emergency Preparedness Committee (Minutes from 191119)** These were accepted by the Committee.		
12	**WORKFORCE** There were no items to discuss.		
13	**HOSPITAL OPTIMISATION UPDATE** The Deputy Chief Nurse drew the Committee's attention to the following		

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	ongoing projects: Outpatient optimisation and CCA rostering. He advised that a table top exercise to look at the allocation of space and efficiency of staffing on the 4th floor was planned for early December, and that the opening of 11 new cardiology beds on 2 December was the first phase of the STP work, for the transfer of acute cardiology patients from CUH to RPH.		
14	**COMMITTEE MEMBER CONCERNS** The Medical Director expressed his concerns over the continued lack of surgical throughput, due to CCA bed availability. There was a wide ranging discussion on the CCA roster and the work being progressed to achieve more efficient rostering. Consideration was being given to splitting the roster in line with the layout of the unit and changes to flexible working patterns were in progress as these were no longer sustainable on the new site. The lack of beds had affected cancellations and had implications on the ability to provide specialist services, transplant, ECMO etc., at an emergency level. There was a further discussion on the risk to the waiting patient and whether this group had sufficient visibility in the organisation. The risks were not confined to medical issues; the social impact of a cancellation could be subtle but enormous. A Governor suggestion of introducing a question about the experience of waiting for treatment at the pre-operative assessment was considered. As more emphasis on through put was required the Medical Director reported that Dr Alain Vuylsteke would be leading on this work. The Chair requested an update on this at the next meeting.		
15	**ANY OTHER BUSINESS** There was no further business.		
16	**ISSUES FOR ESCALATION TO:**		
16.1	**Audit Committee** There were no issues for escalation.		
16.2	**Board of Directors** It was agreed that the CCA capacity issue discussed earlier should be escalated to the Board.		
	Date & Time of Next Meeting: **Tuesday 17th December 2019 - 2.30-4.30 pm, Third floor seminar rooms 1 & 2**		

The meeting finished at 4.45 pm

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Signed

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Date

Royal Papworth Hospital NHS Foundation Trust
Quality and Risk Committee
Meeting held on 26 November 2019